I

111TH CONGRESS
1ST SESSION

H. R. 1940

To amend the Public Health Service Act to establish a Wellness Trust.

IN THE HOUSE OF REPRESENTATIVES

APRIL 2, 2009

Ms. MATSUI (for herself, Mr. BRALEY of Iowa, Mrs. CAPPS, and Mr. SARBANES) introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To amend the Public Health Service Act to establish a Wellness Trust.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Wellness Trust Act''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress finds as follows:

(1) Preventable and chronic diseases are the epidemic of the 21st century. The number of people with chronic conditions is rapidly increasing and it is estimated that, if there is no intervention now, by

2025 nearly half of the United States population will suffer from at least 1 chronic disease. About 70 percent of deaths and health costs in the United States are attributable to chronic diseases (such as cardiovascular disease and cancer), some of which may be preventable. Nearly 90 percent of Medicare beneficiaries have some type of chronic illness.

(2) This affects Americans' health. The United States has the highest rate of preventable deaths among 19 industrialized nations and lags behind 28 other nations in life expectancy. For example, obesity, which is rising rapidly, contributes to a wide range of problems, from diabetes to stroke to cancer. The life expectancy for a 20-year old man may be reduced by 17 percent due to obesity. If trends continue, children's life spans may be shorter than those of their parents for the first time in about a century.

(3) The wellness gap also affects health care costs. About 78 percent of all health spending in the United States is attributable to chronic illness, much of which is preventable. Chronic diseases cost the United States an additional $1,000,000,000,000 each year in lost productivity, and are a major contributing factor to the overall poor health that is

placing the Nation's economic security and competitiveness in jeopardy.

(4) Unlike some health care challenges, proven preventive services and programs exist. If effective risk reduction were implemented and sustained by 2015, the death rate due to cancer could drop by 29 percent. Improved blood sugar control for people with diabetes could reduce the risk for eye disease, kidney disease, and nerve disease by 40 percent. Similarly, blood pressure control could reduce the risk for heart disease and stroke by 33 to 50 percent.

(5) Yet, only half of recommended clinical preventive services are provided to adults. About 20 percent of children do not receive all recommended immunizations, with higher rates in certain areas. Nearly 70 percent of people with high blood pressure do not now control it. And racial disparities in use of prevention exist.

(6) The United States faces low use of preventive services because of the low value placed on prevention, a delivery system bent toward fixing rather than preventing problems, and financial disincentives for prevention. Insurers have little incentive to invest in preventive services today that will benefit other

insurers tomorrow. This is especially true for those preventive services that reduce chronic diseases that develop over a period of several years or decades. The costs of prevention are incurred immediately but most of its benefits are realized later, often by Medicare.

(7) There is a low investment in prevention. The United States spends only an estimated 1 to 3 percent of national health expenditures on preventive health care services and health promotion. This has not increased as much as one might expect since 1929, 1.4 percent, despite the development of expensive screenings, early interventions, and the growth of the preventable disease burden.

(8) The workforce to deliver prevention is also insufficient. The supply of providers who are trained to emphasize prevention is shrinking. Between 1997 and 2005, the number of medical school graduates entering family practice residencies dropped by 50 percent. There is an acute shortage of community health workers. Between 25 and 50 percent of the existing Federal, State, and local public health workforce is eligible for retirement in the next 5 years. As of 2008, more than 75 percent of the existing public health workforce has no formal public health

or prevention training. There is no national, uniform credentialing system for public health or prevention workers that would ensure that these workers are trained in the basics of preventive care.

(9) A system that promoted full use of high-priority prevention could save lives. A recent comprehensive assessment found that 1,200,000 quality-adjusted life years could be saved by achieving 90 percent use of just the following 3 services:

(A) Smoking cessation counseling.

(B) Use of aspirin to prevent heart attacks.

(C) Screening for colorectal cancer.

(10) A system that promoted full use of high-priority prevention could reduce costs. For example, complete, routine childhood vaccination could save up to $40,000,000,000 in direct and societal costs over time. Promoting screenings and behavioral modifications in the workplace can lower absenteeism and, in most cases, health costs to firms. Preventive health care services could reduce government spending on health care. If all elderly received a flu vaccine, health costs could be reduced by nearly $1,000,000,000 per year. Over 25 years, Medicare could save an estimated $890,000,000,000 from ef-

fective control of hypertension, and $1,000,000,000,000 from returning to levels of obesity observed in the 1980s.

(11) Investing in community-level interventions that promote and enable proper nutrition, increased access to physical activity, and smoking cessation programs can prevent and mitigate chronic diseases, improve quality of life, increase economic productivity, and reduce healthcare costs.

(b) PURPOSE.—The purpose of this Act is to create a 21st century prevention system called the Wellness Trust that assures access to clinical and community-level prevention services that improve health, quality of life, and reduce healthcare costs.

SEC. 3. WELLNESS TRUST.

Title III of the Public Health Service Act (21 U.S.C. 241 et seq.) is amended by adding at the end the following:

"PART S—WELLNESS TRUST

"SEC. 399KK. DEFINITIONS; ESTABLISHMENT OF WELLNESS TRUST.

''(a) DEFINITIONS.—In this part:

''(1) CERTIFIED PREVENTION HEALTH WORKER.—The term 'certified prevention health worker' means a licensed health professional, a public health

professional employed by a State or local public health agency, or any other health worker deemed certified by the Trustees.

''(2) PREVENTION HEALTH ENTITY.—The term 'prevention health entity' means a State or local public health agency or other community-based prevention entity deemed to be an eligible Trust participant by the Trustees.

''(3) TRUST.—The term 'Trust' means the Wellness Trust established under subsection (b).

''(4) TRUSTEES.—The term 'Trustees' means the members of the Trust Fund Board appointed under section 399LL(b).

''(b) ESTABLISHMENT OF THE WELLNESS TRUST.—There is established within the Centers for Disease Control and Prevention the Wellness Trust.

''SEC. 399LL. STRUCTURE.

''(a) TRUST FUND BOARD.—The Trust shall be headed by the Trust Fund Board.

''(b) COMPOSITION.—The Trust Fund Board shall be composed of 7 members appointed by the President by and with the advice and consent of the Senate.

''(c) DATE OF APPOINTMENTS.—The initial 7 Trustees shall be appointed not later than December 31, 2009.

''(d) STAGGERED TERMS.—Of the members first appointed under subsection (c)—

''(1) 4 shall be appointed for a period of 4 years; and

''(2) 3 shall be appointed for a period of 3 years.

''(e) VACANCIES.—A vacancy on the Trust Fund Board—

''(1) shall not affect the powers of the Trust Fund Board; and

''(2) shall be filled in the same manner as the original appointment was made.

''(f) MEETINGS.—The Trust Fund Board shall meet at the call of the Chairperson.

''(g) QUORUM; REQUIRED VOTES.—A majority of Trustees shall constitute a quorum for purposes of voting, but a lesser number of members may hold hearings. The Chairperson shall require a vote of the Trustees on major decisions regarding prevention priorities, resource allocation, delivery system structure, and other Trust functions.

''(h) CHAIRPERSON AND VICE CHAIRPERSON.—The Trust Fund Board shall select a Chairperson and Vice Chairperson from among the Trustees.

''(i) REMOVAL.—A Trustee may be removed by the President only for cause.

''(j) RECOMMENDATIONS.—The Trustees may submit recommendations directly to Congress, without opportunity for comment or change by the Secretary.

''(k) STAFF.—The Trustees may employ and fix the compensation of personnel as necessary. Not more than 5 percent of the funds appropriated in a fiscal year to the Trust Fund established under section 399NN may be used to fund the staff, operations, and other purposes as the Trustees determine appropriate of the Trust Fund Board, subject to the oversight of the Secretary.

''SEC. 399MM. REPORTS; PLAN FOR DELIVERY SYSTEMS.

''(a) DEVELOPMENT OF KEY REPORTS.—Not later than 1 year after the appointment of the Trustees under section 399LL(c), the Trustees shall submit to Congress and make publicly available the following reports:

''(1) REPORT ON BROADENING THE PREVENTION WORKFORCE.—A report that develops and describes a system for certification and recertification of 'prevention health workers' to complement the health system and public health infrastructure as in existence at the time of such report. Such system may expand certification efforts in existence at the time of such report for the public health workforce and community health workers. Such report shall also examine the impact of State licensing require-

ments and explore and describe options for health profession training and continuing education, 1 or more registries of certified prevention health workers, and an employment structure that encourages flexible deployment but protects prevention health workers' benefits.

''(2) REPORT ON ALIGNING PAYMENTS WITH PREVENTION GOALS.—A report that examines and describes payment methodologies and presents options for paying certified prevention health workers for clinical preventive care that aligns incentives with goals, as well as payment methodologies for community organizations involved in the provision of prevention services. Such report shall address the shortfalls of the payment systems in existence at the time of such report that have not proven effective at encouraging the provision of prevention services.

''(3) REPORT ON IDENTIFYING EXISTING FUNDING FOR PREVENTION.—A report that examines and describes the amount of money spent on prevention by public health, public and private health insurers, and applicable self-insured health plans (as defined in section 399OO) during the most recent year for which such data is available.

''(b) PLAN FOR DELIVERY SYSTEMS.—Not later than 1 year after the appointment of the Trustees under section 399LL(c), the Trustees shall establish a plan for delivering and financing prevention priorities and implementing pilot programs. Such plan shall include—

''(1) identifying effective delivery systems based on evidence and expert judgment to determine how best to deliver priority clinical and community-based prevention activities;

''(2) assessing the current capacity of effective delivery systems and community infrastructure and actions necessary to ensure adequate infrastructure and capacity to deliver priority clinical and community-based prevention activities as determined by the Trust; and

''(3) identifying cost-saving clinical and community-based interventions to implement before December 31, 2011, which shall include evidence-based interventions in obesity, diabetes, heart disease, and cancer.

''SEC. 399NN. INFRASTRUCTURE AND PRIORITIES.

''(a) DESIGNATING NATIONAL PREVENTION PRIORITIES.—The Trustees shall issue and annually update a ranked list of designated 'prevention priorities'. The inclusion of an activity on such list shall be based on the poten-

tial of such activity to improve health and the cost effectiveness of such activity. Such list shall—

"(1) include clinical preventive services and community-based interventions; and

"(2) be used by the Trustees to—

"(A) determine what prevention services and community-based interventions shall be paid for through the Trust Fund under section 399OO;

"(B) allocate resources within the Trust;

"(C) educate the public on critical prevention priorities; and

"(D) emphasize coverage and use within existing authorities.

"(b) CREATION AND SUPPORT OF INFRASTRUCTURE.—The Trustees shall establish and otherwise support and sustain the infrastructure for an effective wellness system, including the following components:

"(1) CENTRAL SOURCE OF PREVENTION INFORMATION.—A centralized, national, easily accessible information clearinghouse on prevention priorities and community-based interventions that shall—

"(A) be made available in multiple media;

"(B) be updated regularly; and

"(C) connect individuals, health care providers, State and local health departments, and others to national and local resources that support the designated prevention priorities under subsection (a).

"(2) QUALIFIED ELECTRONIC HEALTH RECORDS.—The use and integration of qualified electronic health records (as defined in section 3000(13))—

"(A) to track provision of prevention over the course of individuals' lifetimes;

"(B) to facilitate reimbursement of certified prevention health workers and prevention health entities; and

"(C) to assist in evaluations of the efficacy of the policies of the Wellness Trust.

"(3) SYSTEM FOR TRAINING AND CREDENTIALING PREVENTION HEALTH WORKERS.—A system for training and credentialing prevention health workers and prevention health entities through agencies such as the Health Resources and Services Administration and the Centers for Disease Control and Prevention. In establishing and implementing such system, the Trustees shall—

''(A) provide funding to such agencies through the Trust Fund under section 399OO;

''(B) establish a central registry of certified prevention health workers and prevention health entities; and

''(C) encourage such workers to access additional training.

''SEC. 399OO. FUNDING FOR WELLNESS TRUST.

''(a) INITIAL FUNDING.—There is authorized to be appropriated and there is appropriated to the Trust Fund Board such sums as may be necessary to carry out sections 399MM and 399NN and other activities necessary for the implementation of this part.

''(b) ESTABLISHMENT OF WELLNESS TRUST FUND.—Not later than January 1, 2011, there shall be established in the Treasury of the United States a trust fund to be known as the 'Wellness Trust Fund' (referred to in this section as the 'Trust Fund'), consisting of such amounts as are appropriated or credited to the Fund as provided under this section.

''(c) APPROPRIATIONS TO THE FUND.—

''(1) FISCAL YEAR 2011.—There is hereby appropriated to the Trust Fund for fiscal year 2011 an amount equal to the amount spent by all Federal health programs to pay for prevention services (as

defined by the Preventive Services Task Force convened under section 915, except the definition of such services shall not be limited to those designated by the Task Force) in the most recent year for which complete data is available, as estimated by the Trustees.

''(2) FISCAL YEAR 2012.—There is hereby appropriated to the Trust Fund for fiscal year 2012 the amount appropriated to the Trust Fund for the previous fiscal year, increased by the annual percentage increase in the medical care component of the consumer price index (United States city average) for the 12-month period ending with April of the preceding fiscal year.

''(3) FISCAL YEAR 2013 AND SUBSEQUENT YEARS.—There is hereby appropriated to the Trust Fund for fiscal year 2013 and each subsequent fiscal year an amount equal to the sum of—

''(A) the amount appropriated to the Trust Fund for the previous fiscal year, increased by the annual percentage increase in the medical care component of the consumer price index (United States city average) for the 12-month period ending with April of the preceding fiscal year;

''(B) the amount collected by the Secretary from health insurance issuers and applicable self-insured health plans under subsection (d) for the fiscal year; and

''(C) the amount associated with prevention priorities for State and local spending, under-use, and the uninsured for the fiscal year, as estimated by the Trustees (which shall not exceed the amount equal to 10 percent of the amount otherwise appropriated to the Trust Fund for the fiscal year).

''(4) AVAILABILITY.—Amounts appropriated pursuant to this subsection shall remain available until expended.

''(d) ASSESSMENT OF HEALTH INSURANCE ISSUERS AND APPLICABLE SELF-INSURED HEALTH PLANS.—

''(1) IN GENERAL.—Beginning in fiscal year 2013 and on an annual basis thereafter, the Secretary shall, subject to paragraph (2), assess and collect a fee from each health insurance issuer and each applicable self-insured health plan in an amount equal to the estimated amount spent by such health insurance issuer and self-insured health plan, respectively, for prevention services (as defined by the Trustees).

''(2) COLLECTION AMOUNT ADJUSTMENT BEGINNING IN FISCAL YEAR 2013.—The amount determined under paragraph (1) shall, on an annual basis, be increased by the annual percentage increase in the medical care component of the consumer price index (United States city average) for the 12-month period ending with April of the preceding fiscal year.

''(e) DEFINITIONS.—In this section:

''(1) APPLICABLE SELF-INSURED HEALTH PLAN.—The term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

''(A) any portion of such coverage is provided other than through an insurance policy; and

''(B) such plan is established or maintained—

''(i) by 1 or more employers for the benefit of their employees or former employees;

''(ii) by 1 or more employee organizations for the benefit of their members or former members;

"(iii) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees;

"(iv) by a voluntary employees' beneficiary association described in section 501(c)(9) of the Internal Revenue Code of 1986;

"(v) by any organization described in section 501(c)(6) of such Code; or

"(vi) in the case of a plan not described in the preceding clauses, by a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

"(2) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage

in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974).

''(3) HEALTH MAINTENANCE ORGANIZATION.—The term 'health maintenance organization' means—

''(A) a Federally qualified health maintenance organization (as defined in section 1301(a));

''(B) an organization recognized under State law as a health maintenance organization; or

''(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

''SEC. 399PP. INSURING PREVENTION PRIORITIES.

''(a) WELLNESS TRUST AS PRIMARY PAYER FOR PREVENTION SERVICES.—The Trust shall enter into contracts with certified prevention health workers and prevention health entities to reimburse such workers and entities for the prevention services and community-based interventions designated by the Trustees under section 399NN as prevention priorities.

''(b) PRIORITIES.—The Trustees shall develop annual and 5-year budget targets for the designated prevention priorities under section 399NN, including clinical preventive services and community-based interventions. The Trustees shall publish annually a list indicating which of these prevention priorities are eligible for funding through the Fund.

''(c) ELIGIBLE INDIVIDUALS AND ENTITIES.—Pursuant to the contracts described under subsection (a), the Trust shall reimburse certified prevention health workers and prevention health entities for the prevention services and community-based interventions described under such subsection provided to all individuals who are United States citizens or legal immigrants, without regard to the insurance status of such individuals.

''(d) DEVELOPMENT, REFINEMENT, AND CHANGE OF PAYMENT SYSTEMS.—The Trustees shall determine payment methodologies for prevention priorities. Such payment methodologies shall correspond to the following tiers of activity:

''(1) COMPETITIVE CONTRACTING AUTHORITY.—The Trustees shall have a competitive contracting authority for the national delivery system activities.

''(2) DIRECT PAYMENT SYSTEMS.—The Trustees shall develop different payment methodologies for the various designated prevention services and community-based interventions. These payment systems shall take into account existing rates, rates for similar services, and whether geographic adjustment is needed. Such systems shall link the priority of the service with payments.

''(3) USE OF STATE AND LOCAL GRANT SYSTEMS.—The Trustees shall utilize existing grant programs where feasible to distribute funds from the Trust Fund for prevention priorities.

''(4) REPORTS FROM FEDERAL PROGRAMS.—Programs that receive funding for prevention priorities through the Trust Fund shall report annually to Congress on the extent to which this funding displaces existing spending on prevention priorities.

''(e) PARTNERSHIP WITH MEDICARE AND OTHER INSURERS.—The Trustees shall determine the most efficient way to transfer funds from the Trust Fund to certified prevention health workers and prevention health entities. In making such determination, the Trustees shall carry out the following:

''(1) COORDINATION WITH MEDICARE.—The Trustees shall examine the use of Medicare systems

for direct payments to certified prevention health workers and prevention health entities. Any additional administrative cost associated with the use of the payment systems, including those of a broader set of providers, shall come from the Trust Fund.

''(2) CONTRACT WITH OTHER INSURERS.—To the extent that the Medicare program, private insurers, or States prove that such program, insurer, or State has the capacity to deliver prevention priorities in a cost effective manner, the Trustees may contract with such entity for delivery of prevention services covered under this Trust Fund.''.

SEC. 4. INTEGRATION OF PREVENTION HEALTH RECORD.

Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.) is amended—

(1) in section 3000(13)(B)—

(A) in clause (iii), by striking ''and'' at the end;

(B) in clause (iv), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(v) to track the provision of prevention health care over the course of the individual's lifetime and assist in evaluations

of the efficacy of prevention priorities designated under section 399NN.'';

(2) in section 3002(b)(2)(B), add at the end the following:

''(ix) The integration and inclusion of preventive and community-based health care services in any qualified electronic health record, in order to allow individuals and caregivers to track the provision of preventive health care services.''; and

(3) in section 3011(a), add at the end the following:

''(8) Integration of prevention health priorities, prevention data, and tracking of the provision of preventive care by means of qualified electronic health records.''.

○